



PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)	#	SYMPTOMS
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of <input type="checkbox"/> Dental Changes <input type="checkbox"/> Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	13 Do you experience pain in » Jaw <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Face <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Neck <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Shoulders <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Arms <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year
2	Where do you think your teeth hit or fit first? <input type="checkbox"/> More on the right <input type="checkbox"/> Left <input type="checkbox"/> Equal <input type="checkbox"/> More on the front <input type="checkbox"/> Back <input type="checkbox"/> Equal		14 Do you experience ringing or fullness in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No » Which one? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
3	Do your jaw muscles get tight or sore? » When? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> After chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	15 How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication? <input type="checkbox"/> Occasionally <input type="checkbox"/> More than twice a year <input type="checkbox"/> More than once a month <input type="checkbox"/> More than once a week <input type="checkbox"/> Never
4	Do you have pain or difficulty opening wide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16 How often do you get other milder headaches? <input type="checkbox"/> Daily <input type="checkbox"/> More than 3 per week <input type="checkbox"/> More than 2 per month <input type="checkbox"/> Other _____
5	Are you aware of noises in your jaw joints? <input type="checkbox"/> Popping <input type="checkbox"/> Clicking <input type="checkbox"/> Other » Where? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both » How long? <input type="checkbox"/> Less than 1 year <input type="checkbox"/> More than 1 year	<input type="checkbox"/> Yes <input type="checkbox"/> No	17 Have your headaches changed in the last six months? <input type="checkbox"/> About the same <input type="checkbox"/> Slight worsening <input type="checkbox"/> Same but more frequent <input type="checkbox"/> A lot worse Got worse when _____
CAUSES & COMPLICATIONS		IMPACT ON DAILY LIVING ACTIVITIES	
6	Do you grind or clench your teeth? » Do you wear a? <input type="checkbox"/> Splint <input type="checkbox"/> Night Guard <input type="checkbox"/> Retainer	<input type="checkbox"/> Yes <input type="checkbox"/> No	18 What is your stress level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
7	Have you had any significant dental treatments? <input type="checkbox"/> Orthodontics <input type="checkbox"/> Oral surgery / wisdom teeth removal <input type="checkbox"/> Long dental appointments <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	19 Do you have anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? <input type="checkbox"/> 0-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than 1 year » Did you see the accident coming? <input type="checkbox"/> Yes <input type="checkbox"/> No » Did the airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	20 Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days you did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____
9	Have you had sports injuries and/or trauma to your head & neck? » When? <input type="checkbox"/> Less than 1 year <input type="checkbox"/> More than 1 year	<input type="checkbox"/> Yes <input type="checkbox"/> No	21 When you have pain, headaches or migraines, how does that make you feel? (Check all that apply) <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Tired or exhausted <input type="checkbox"/> Frustrated <input type="checkbox"/> Guilty <input type="checkbox"/> Ashamed <input type="checkbox"/> Relationship tension <input type="checkbox"/> Other _____
10	Do you work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	22 How many days per month are you:  Pain Free? _____  Headache Free? _____
11	Daytime sleepiness, drowsiness, or tiredness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12	Problems with sleep? » Insomnia <input type="checkbox"/> Yes <input type="checkbox"/> No » Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No » Sleep Disturbances <input type="checkbox"/> Yes <input type="checkbox"/> No » Less than 7 hours per night <input type="checkbox"/> Yes <input type="checkbox"/> No » Other _____		NOTES: _____ _____ _____ _____